Udhaya Kumar a/l Karuppusamy & Anor v Penguasa Hospital Daerah Pontian & Ors

HIGH COURT (MUAR) — CIVIL SUIT NO 22–15 OF 1997
JEFFREY TAN J
19 MARCH 2004

Evidence — Adverse inference — Failure to produce material evidence — Medical records destroyed after seven years since not needed for medico-legal reason — Whether s 114(g) Evidence Act 1950 could be invoked

Evidence — Burden of proof — Negligence — Whether onus on plaintiff to show causative link existed between resultant damage and negligent act

Tort — Negligence — Professional negligence — Damages — Loss of amenities and nursing care — Severe mental retardation — Whether nursing care could be awarded when no evidence led on that claim

Tort — Negligence — Professional negligence — Standard of care — Medical practitioners — Whether treatment and diagnosis in accordance with standards of reasonably competent medical men at the time

This was an action brought by a father ('the second plaintiff') on behalf of his mentally retarded son ('the first plaintiff') whom the father claimed became retarded as a result of delayed treatment and/or improper diagnosis and treatment by the first defendant or second defendant. The defendants on the other hand contend that there was no negligence and or breach of duty on the part of the first and second defendants. The defendants could produce none of the medical records of the first plaintiff at the second defendant hospital. There was also no evidence adduced for nursing care by the plaintiffs.

Held, dismissing plaintiffs' claim:

(1) An adverse inference under s 114(g) of the Evidence Act 1950 can only be drawn if there is withholding or suppression of evidence and not merely on account of failure to obtain evidence. There was no withholding or suppression of evidence in the instant case. It would not be unfair to say that the non-availability of the inpatient records of the first plaintiff was brought about solely by the plaintiffs. The plaintiffs could not expect the defendants to keep their records forever. And the plaintiffs should not lay blame at the defendants' door for their own inertia (see para 31); *Munusamy v Public Prosecutor* [1987] 1 MLJ 492 followed.

(2) The plaintiffs failed to offer proof that the diagnosis and treatment were not in accordance with the standards of reasonably competent medical men at the time. In the result, the plaintiffs had not proved negligence against the first defendant (see para 43).

(3) It would be an absolute travesty if the defendants were made to answer for the plaintiffs' failure to discharge the burden of proof. The onus was on the plaintiffs to show, on a balance of probabilities, that there was a causative link between the resultant damage and the negligent act of the defendants as in *Wiltsher v Essex Area Health Authority* [1988] 1 All ER 871. But the plaintiffs failed to show that the resultant mental retardation was caused by any negligent act of the defendants (see para 43).

(4) The court awarded RM200,000 for loss of amenities due to severe mental retardation and although no evidence was led it must stand to reason that the first plaintiff would need constant care. That would involve expense. The sum sought was moreover not unreasonable. The award was a sum of RM600 per month towards pre-trial and post trial nursing care for 35 years (see para 44).

[**Bahasa Malaysia summary**

Ini adalah tindakan yang dibawa oleh ayah ('plaintif kedua') bagi pihak anaknya yang cacat akal ('plaintif pertama') yang mendakwa anaknya cacat akibat lambat untuk berubat dan/atau diagnosis dan perubatan yang tidak sesuai yang diberikan oleh defendan pertama atau defendan kedua. Defendan-defendan pula mendakwa bahawa tiada kecuaian atau kemungkiran tanggungjawab oleh defendan pertama dan defendan kedua. Defendan-defendan tidak dapat kemukakan sebarang rekod perubatan plaintif pertama dalam hospital defendan kedua. Tiada keterangan juga dikemukakan oleh plaintif-plaintif mengenai penjagaan jururawat.

Diputuskan, menolak tuntutan plaintif-plaintif:

(1) Andaian bertentangan di bawah s 114(g) Akta Keterangan 1950 hanya boleh dibuat jika terdapat penyembunyian atau sekatan terhadap keterangan dan bukan hanya kerana gagal untuk mendapatkan keterangan. Tiada keterangan disekat atau dihalang dalam kes semasa. Ia adalah tidak adil untuk mengatakan bahawa ketiadaan rekod-rekod pesakit dalaman plaintif pertama adalah akibat plaintif-plaintif semata-mata. Plaintif-plaintif tidak boleh diharapkan menyimpan rekod-rekod mereka selama-lamanya. Dan plaintif-plaintif tidak sepatutnya meletakkan kesalahan terhadap defendan-defendan akibat inersia mereka sendiri (lihat perenggan 31); *Munusamy v Public Prosecutor* [1987] 1 MLJ 492 diikut.

(2) Plaintif-plaintif gagal untuk mengemukakan bukti bahawa diagnosis dan rawatan tersebut tidak menurut standard pengamal perubatan berkelayakkan yang munasabah pada masa itu. Akibatnya, plaintif-plaintif tidak membuktikan kecuaian terhadap defendan pertama (lihat perenggan 43).

(3) Ia adalah tindakan yang teruk jika defendan-defendan perlu menjawab kegagalan plaintif-plaintif untuk melepaskan beban bukti. Beban bukti

adalah untuk plaintif-plaintif menunjukkan, atas imbangan kebarangkalian, bahawa terdapat kaitan penyebab antara kerugian yang dialami dan tindakan kecuaian defendan-defendan seperti dalam kes *Wiltsher v Essex Area Health Authority* [1988] 1 All ER 871. Tetapi plaintif-plaintif telah gagal untuk menunjukkan bahawa kecacatan akal yang dialami adalah akibat tindakan kecuaian defendan-defendan (lihat perenggan 43).

(4) Mahkamah mengawardkan RM200,000 untuk kehilangan kemudahan akibat kecacatan akal yang teruk dan walaupun tiada keterangan yang diberikan, ia boleh difahami bahawa plaintif pertamamemerlukan jagaan pada setiap masa. Ini memerlukan perbelanjaan. Wang yang dituntut adalah bukan tidak munasabah. Keputusan adalah RM600 sebulan untuk penjagaan jururawat sebelum dan selepas perbicaraan untuk 35 tahun (lihat perenggan 44).]

Notes

For cases on failure to produce material evidence, see 7(2) *Mallal's Digest* (4th Ed, 2003 Reissue) paras 184–186.

For cases on negligence, see 7(2) *Mallal's Digest* (4th Ed, 2003 Reissue) paras 484–491.

For cases on professional negligence, see 12 *Mallal's Digest* (4th Ed, 2002 Reissue) paras 945–1013.

For burden and standard of proof in civil cases, see 12 *Halsbury's Laws of Malaysia* paras [210.018]–[210.021].

For standard of care in negligence, see 5 *Halsbury's Laws of Malaysia* paras [80.143]–[80.146].

For damages in negligence generally, see 5 *Halsbury's Laws of Malaysia* paras [80.126]–[80.232].

Cases referred to

Ahmad Daman Huri bin Hussein v Koo Chin Yau [1990] 3 MLJ 53 (refd)
Albrighton v Royal Prince Alfred Hospital [1980] 2 IMSWLR 542 (refd)
Battersby v Tottman (1985) 37 SASR 524 (refd)
Bolam v Friern Hospital Management Committee [1957] 2 All ER 118 (folld)
Bolitho v City and Hackney Health Authority [1997] 4 All ER 771 (refd)
Chin Keow v Government of Malaysia & Anor [1967] 2 MLJ 45 (folld)
Dr Chin Yoon Hiap v Ng Eu Khoon & Ors and other appeals [1998] 1 MLJ 57 (refd)
Dr Soo Fook Mun v Foo Fio Na & Anor and another appeal [2001] 2 MLJ 193 (refd)
Elizabeth Choo v Government of Malaysia & Anor [1970] 2 MLJ 171 (refd)
Ellis v Wallsend District Hospital (1988 unreported) (refd)
E v Australian Red Cross Society (1991) 99 ALR 601 (refd)
F v Chan Fanny [2003] 4 SLR 231 (refd)
F v R [1984] 33 SASR 189 (refd)

Gover v South Australia (1985) 39 SASR 543 (refd)
Hong Chuan Lay v Dr Eddie Soo Fook Mun [1998] 7 MLJ 481 (refd)
Hunter v Hanley [1955] SLT 213 (refd)
Inderjeet Singh a/l Piara Singh v Mazlan bin Jasman & Ors [1995] 2 MLJ 646 (refd)
Jamil bin Harun v Yang Kamsiah & Anor [1984] 1 MLJ 217(refd)
Kamalam a/p Raman & Ors v Eastern Plantation Agency (Johore) Sdn Bhd Ulu Tiram Estate, Ulu Tiram, Johore & Anor [1996] 4 MLJ 674 (refd)
Kow Nan Seng v Nagamah & Ors [1982] 1 MLJ 128 (folld)
McGhee v National Coal Board [1972] 3 All ER 1008 (refd)
Munusamy v PP [1987] 1 MLJ 492 (folld)
Naxakis v Western General Hospital [1999] HCA 22 (refd)
R (on the application of N) v Doctor M and others [2002] EWCA Civ 1789 (refd)
Rogers v Whitaker [1992] 109 ALR 625 (refd)
Wiltsher v Essex Area Health Authority [1988] 1 All ER 871 (refd)
Yang Salbiah & Anor v Jamil bin Harun [1981] 1 MLJ 292 (refd)

Legislation referred to

Evidence Act 1950 s114(g)

Harjit Singh Nijar (Nijar & Nijar) for the plaintiffs.
Alice Loke Yee Ching (Attorney General's Chambers) for the defendants.

Jeffrey Tan J:

[1] To all intents and purposes, this is an action brought by a father (second plaintiff) on behalf of his mentally retarded son (first plaintiff) whom the father claims became retarded as a result of delayed treatment and or improper diagnosis and treatment by the Pontian District Hospital (first defendant)/Sultanah Aminah Hospital Johor Bahru (second defendant).

[2] It is not in dispute that the first plaintiff (then aged 1 year and 10 months) was admitted on 21 March 1978 to the Pontian District Hospital for treatment, that the first plaintiff was warded at the Pontian District Hospital between 21 March 1978 to 23 March 1978, and that the first plaintiff became mentally retarded on or about 21 March 1978. The plaintiff's documents (PB(1-6)) are agreed documents with regard to both admissibility and content. What is in dispute is the cause for the mental state of the first plaintiff. Stated briefly, the plaintiffs contend that mental retardation was a result of delay on the part of the first and second defendants in treating the first plaintiff and or a result of improper diagnosis and improper treatment on the part of the first and second defendants, while the defendants contend that there was no negligence and or breach of duty on the part of the first and second defendants.

[3] Both sides summoned medical doctors as witnesses. But the scene was set by the first plaintiff, a humble labourer attached to the Drainage & Irrigation Department, Pontian, who testified, remarkably in impeccable English, as follows. The first plaintiff, his eldest son, was born on 14September 1976. At 1am on 21 March 1978, he admitted the first plaintiff with a high fever to the Pontian District Hospital. A hospital attendant summoned for the doctor on duty. But no doctor attended to the first plaintiff. One Dr Jasbir Kaur only attended to the first plaintiff at 10am. Between 1am to 10am, the first plaintiff was in the ward. The first plaintiff was given a cold bath, and some medical syrup. The first plaintiff's temperature was monitored. Between 1am to 10am, the body of the first plaintiff was twisting, and his eyes were looking backwards. Later he got to know that it was fits. Many a time he asked for a doctor. Dr Jasbir told him that it was normal fever, and that there was nothing dangerous. The same medicine was administered. Treatment was delayed. It was the same treatment until 23 March 1978. At midday on 23 March 1978, a nurse asked him to follow her. He followed her to the kitchen. The nurse advised him to immediately admit the first plaintiff to the second defendant hospital if he wanted to see his son alive. He was both puzzled and frightened. He requested for the transfer of the first plaintiff to the second defendant hospital. That evening, an ambulance transferred the first plaintiff to the second defendant hospital. At the second defendant hospital, he saw one Dr Thiagi, who had the medical report of the Pontian Hospital. The first plaintiff was warded. The first plaintiff was tied to the railing of the bed, to stop him from twisting and turning. The first plaintiff was given drips. Dr Thiagi told him that he had gone through the medical record. Dr Thiagi asked 'why had the Pontian Hospital sent the first plaintiff only now?'. Dr Thiagi said 'why had Pontian Hospital sent a body to JB Hospital?'. Dr Thiagi said he would call for a senior doctor. At 2am on 24March 1978, a Chinese doctor attended to the first plaintiff. The first plaintiff was taken into the X–ray room. Dr Thiagi told him that an X–ray was taken of the head of the first plaintiff, and that 25% - 85% of the brain cells of the plaintiff had been 'burnt'. The first plaintiff was warded at the JB Hospital for two weeks. There was follow-up treatment for many years. The first plaintiff needs constant care. On 22 September 1999, two doctors examined the first plaintiff, at the request of the Ministry of Health. Fits only occurred at the Pontian Hospital.

[4] Under cross-examination, the second plaintiff said that the first plaintiff was an active child, but was idle and very quiet on the night of 20March 1978. The body of the first plaintiff was hot. He thought it was fever. After the first plaintiff was discharged on 7 April 1978, he could not walk. The first plaintiff could not walk for many years. 'He returned as a bed-ridden patient for many years'.

[5] Under re-examination, the second plaintiff said that prior to his illness his son was perfectly normal. 'After his discharge from JB Hospital, the first plaintiff was no longer normal. He had to relearn to stand and walk. The first plaintiff is now well built, but is unable to do simple things.

The first plaintiff cannot even chew his food. He swallows his food. Even after 20 years of training and guidance, the first plaintiff is still swallowing his food. We have to do all things for him'.

[6] The first medical witness for the plaintiffs was one Dr Khairuddin bin Abdul Wahab (PW1 — a government psychiatrist attached to the Permai Hospital where the first plaintiff was treated for a period) who testified that the first plaintiff was in an advanced state of mental retardation since he was three or four years old. The rest of PW1's testimony was as follows. The cause was probably due to an infection during infancy, an infection caused by meningitis or encephalitis. In either case, fever would be a symptom. With symptoms of fits and fever, a doctor should be able to diagnose meningitis. 'To be sure, the other symptoms are stiffness of the neck and weakness in either the upper or lower limbs. Any medical doctor should know the above. In the case of the treatment for meningitis, lumbar puncture is a standard procedure ... since the 1960s. Lumbar puncture is a test to confirm the condition of the brain. Fluid is taken from the lumbar column and tested for bacteria. That would enable a very precise treatment ... Any medical doctor should be able to perform a lumbar puncture ... It is possible that the first plaintiff is mentally retarded because of some viral fever when he was young, but because of the history of treatment for fever and fits at the Pontian Hospital, I would say that the mental retardation was related to fever and fits. Fever and fits are symptoms of meningitis or other infections. Serious malaria would show the same symptoms. A lumbar puncture is a medical procedure to establish the diagnosis of meningitis. Sponging a patient with fever and fits would lower the body temperature. But it would not treat meningitis. A lumbar puncture is standard procedure if meningitis is suspected. A lumbar puncture is not performed if meningitis is excluded. A lumbar puncture is not dangerous. Any doctor should be able to perform a lumbar puncture. It is part of a doctor's training. Pyrexia is fever. A doctor may rule out meningitis if fever and fits is only for a short duration, one or two hours. But if it is longer, meningitis should not be ruled out. In this case, because fever and fits were for a long time, meningitis should not be ruled out. But lumbar puncture need not be performed immediately upon admission. It is done after observation'.

[7] When he was recalled, PW1 further testified that he was one of the members of the medical panel who examined the first plaintiff on 13 November 1999, that D1 was the report of the panel, and that the other members of the panel (Dato' Dr Singaveloo and Dr Soo See Woon) were not psychiatrists. PW1 opined that the mental retardation of the first plaintiff was caused by meningitis or encephalitis.

[8] The other medical witness for the plaintiffs was Dr Rooshamini Merican bt A Rahim (PW2 — a government paediatrician attached to the Johor Medical Department) who said she prepared PB6 (a transcript of the Pontian Hospital's outpatient record of the first plaintiff, and which transcript is also D2B) from the available medical records. PW2 said she had no idea of the treatment given to the first plaintiff.

[9] It is now germane to reproduce the medical records of the first plaintiff, produced by the plaintiffs and defendants:

(PB6)

UNIT REKOD PERUBATAN

HOSPITAL PONTIAN 82000 JOHOR.

(4) dim. RP/LP5 Pay 95

Maklumat Pesakit:

Nama UDHAYAKUMAR KARUPPASAMY Tkh Rawatan 21.03.78

No K/P: A 3477918

No Daftar: 2871/78

Umur: 1 + th

Jantina: Lelaki

Pegawai Perubatan yang menu/is laporan: DR. ROOSAHIMI MERICAN BTE ARAHIM MERICAN

Laporan Perubatan:

Case was seen by doctor on duty in Casualty on 21/3/78 and reported as follows:

Indian male over 1 year of age.

History of fever associated with cough for past 2 days associate with fits tonight 2 times.

On Examination: General condition fair

Febrile temperature 104° F by axilla

Throat clear.

No L/N enlargement noted.

Vital signs stable.

Patient was admitted to ward on 21/3/78 for pyrexia of unknown origin with febrile fits.

Patient was not responding to treatment well in the ward and was referred to General Hospital Johor Bahru on 23/3/78.

REPORT PREPARED BY DR ROOSHAIMI MERICAN BTE A RAHIM MERICAN.

(PB7)

HOSPITAL PERMAI

Tarikh 28hb Mac 1996

Nijar & Nijar,

Tuan/Puan,

Per: Lapuran Psikiatri keatas

UDHAYA KUMAR KARUPPUSAMY KP: A 3477918

Surat tuan bil, MKN/7524/94 yang bertarikh 3.3.96 adalah dirujuk.

2 Penama diatas telah menjalani pemeriksaan psikiatri pada 24.1.96 di Hospital Suftanah Aminah, Johor Bahru. Sehubungan dengan itu beliau telah dimasukkan di hospital Permai untuk pemerhatian dan pemeriksaan yang lebih lanjut dari 30.1.96 hingga 6.2.96.

3 Dari sejarah penyakit yang diberikan oleh bapanya dan dari pemerhatian yang dijalankan didalam wad hospital adalah didapati bahawa beliau mengidap terancat akal yang 'teruk' (severe mental retardation). Beliau tidak boleh bercakap atau menulis. Beliau juga tidak berupaya menjaga diri sendiri seperti makan minum dan kebersihan badan. Disamping itu beliau mempunyai akal yang terlalu rendah (very poor intelligence).

3 Keadaan mentalnya tidak boleh dipulihkan dengan rawatan dan beliau sentiasa memeriukan penjagaan yang rapt daripada keluarganya.

Sekian, terima kasih. "BERHIDMAT UNTUK NEGARA"

Saya Yang Menurut Perentah,

Dr Rajinder Singh

Pakar Perubatan Jiwa,

Hospital Permai.

[10] The report (Dl) of the medical panel reads as follows:

UNIT REKOD PERUBATAN

HOSPITAL PONTIAN

Tarikh 13.11.1999

Maklumat Pesakit:

Nama	UDHAYAKUMAR KARUPPUSAMY	
No K/P:	A 3477918(0) 76914-01-7741(N)	
BANGSA:	INDIA	Age 1978 - 2 yrs old
Jantina:	Lelaki	Age 1999 - 23 yrs old

Medical Report:

History from his father:

On 20th March 1978, when his child was 1 year old, his child developed fever at around 10 pm. He brought his child to Hospital Pontlan at 1 am on 21st March 1978.

His child was attended to by a Medical Assistant (MA). The father complained that his child had fever and cough, and fitted 2 times. On examination, the temperature was 104 F by axilla, throat was clear, no palpable lymph node, no palpable liver or spleen.

The Medical Assistant then was alleged to have consulted the doctor on call. The MA was advised to admit the child and treat with paracetamol, phensedyl and tepid sponging PRN. He was also alleged to have advised to call the doctor when necessary.

No notes are available regarding the admission because BHT (Patient's Admission Notes) were destroyed as per government regulation.

OPD card shows the child was referred to Hospital Sultanah Aminah, Johor Baru on 23 March 1978 and diagnosed as Pyrexia of unknown origin and febrile fits. The child was given Erythromycin and then penicillin. But the temperature was still spiking and still had convulsions despite valium inj. given.

The child was transferred to Hospital Aminah, Johor Baru (HSAJB) by 5.30 p.m. on 23 March 1978. On arrival in Hospital Sultanah Aminah, Johor Baru Paediatric ward, the child was kept 14 days, and was discharged well with no more temperature or fits. The father was advised follow up weekly, monthly and then yearly.

Subsequently the father noticed his child wasn't able to respond to call. He took a long time to turn his head towards any sound.

MILESTONES Standing at 4 years of age

Walking at 6 years of age

Bed wetting until 11 years of age

Over the years, the child has grown physically but mentally and psychologically has been impaired.

Example:
i) earning ability is grossly impaired and not trainable
ii) memory is poor
iii) easily agitated
iv) can be aggressive but now controlled with drug therapy
v) daily life activities are very dependant on family, example eating, bathing, clothing
vi) masturbates without inhibition
vii) opens bowel and passing urine without inhibition in the house.

Medical History

No major medical illness except for URT1 and skin problem

Patient was on medication from Hospital Permai for mental retardation and aggressive behaviour since 30th Jan. 1996, currently taking 3 drugs from Hospital Permai

On examination:

Patient was smiling, no drooling of saliva, approachable, tendency to hold on to his father in a sense of insecurity.

Able to obey very primitive commands: example sitting, standing and walking.

Unable to mention his name.

On general examination:

No pallor/jaundice/lymph node/clubbing/cyanosis

Skin: pruritic marks

Fundus: NAD (No abnormality detected)

Lungs: Clear

CVS: DRNM (dual rhythm, no murmur)

Per-abdomen: no organomegaly

Genital organ: normal

CNS: cranial nerve intact

Motor System normal

Sensory System not tested

Reflex intact

No obvious cerebellar sign

Able to write zero, unable to copy

MRI Brain (not possible as patient is restless apprehensive and easily agitated)

Diagnosis

1 Febrile fits in childhood

2 Severe mental retardation and aggressive behavious

3 Normal physical build

Current Treatment

From Hospital Permai to control aggressive behaviour.

Report Prepared by:

Dato Dr Singaveloo Pakar Perunding Perubatan Kanan

Hospital Sultanah Aminah,

Johor Baru

Dr Khalruddin bin A Wahab, Pakar Pslakiatri

Hospital Permai

Johor Baru

Dr Soo See Woo

Pegawai Perubatan Hospital

Pontian

[11] The defendants also produced the outpatient card (D2B) of the first plaintiff, and the referral letter (D2A) of the first defendant to the second defendant.

(D2B)

KAD RAWATAN UNTUK ORANG SAKIT (WAR)

Nombor pendaftaran: 2871/78

Nama: UDHAYA KUMAR A/L KARUPPUSAMY

Alamat: Ladang Kukup

Tarikh Masuk Rumah Sakit	L A 3477918	
Tarikh:	Nota	Rawatan
21 Mar 1978		
@ 3.00am	c/o fever and cough X 2 days	(1) Syrup paracetamol
	O/e Temperature 104 F by axilla	(2) Syrup phensedyl
	- No vomiting	(3) Tepid sponge prn
	Tonight fits 2 times	
	Throat clear	
	O? febrile fits	To inform Doctor in the prn
		Admit ward

D/A 21.3.78

D/D 23.3.78 refer to GHJB

R/N 1469

PUO with febrile fits

Pyrexia of unknown origin

(D2A)

Casualty

GHJB

RE: Udhaya Kumar a/l Karuppusamy Diagnosis

Pyrexia of unknown origin

Dear Dr,

This patient was admitted with febrile fits, was on Syrup Erythromycin for 2 days. Today was changed to Injection Crystalline Penicillin 1 dose at 12 noon given. He is not responding. Temperature still spiking. Had convulsions 1/2 minute today. Injection vallum 2.5 mg I.M stat given.

On examination Throat No Abnormality Detected

No glands enlarged or liver/spleen enlarged

Heart No Abnormality Detected

Blood Film for Malaria Parasites:

Negative

Referring for further investigation

Pegawai Perubatan
Hospital Pontian

[12] The first of the two doctors summoned by the defendants was Dato' Dr Singaveloo (DW1 — a government doctor who retired in 2002 as a government consultant physician and State Physician), who affirmed that he was one of the members of the medical panel who examined the first plaintiff on 13 November 1999, and who testified as follows. The panel had sight of the medical records of the outpatient department of the Pontian Hospital. The panel was informed that the inpatient record of the first plaintiff had been destroyed. It is the practice to destroy all records after the passage of seven years, if it is not needed for medico-legal reasons. That would have been the case of the inpatient record of the first plaintiff. Febrile fits was diagnosed by the second defendant. Febrile fits is high temperature in children causing fits. If febrile fits is not treated, the child could develop brain damage. Repeated fits could cause anoxia (lack of oxygen), and that could damage several organs, normally the heart, brain, kidneys and tissues. Meningitis is a special infection affecting the meninges, the membrane that covers the brain and spinal cord. Meningitis is caused by organisms, such as virus (the most common organism), bacteria or fungus, from within or from outside the body. The infection of the first plaintiff could have been caused not just by meningitis or encephalitis. The symptoms in meningitis also apply to encephalitis. Virus could attack the membrane (meningitis) or the brain (encephalitis) or both. Meningitis could or could not have been the cause in the instant case. DWI could not specify

the cause for the retardation of the first plaintiff. Erythromycin and C penicillin would be adequate treatment in the case of simple bacteria fever. DWI said he agreed with the diagnosis of pyrexia of unknown origin and febrile fits. But DWI could not say if it was necessary to ward the first plaintiff for 14days at the second defendant Hospital. Febrile fits is common, but meningitis is the cause in only 10%–15% of the cases. Febrile fits is a symptom, just as pain is a symptom. In the case of meningitis, a patient would be warded for at least a week. At the Pontian Hospital, erythromycin and C penicillin would be adequate treatment. Thereafter the patient should be referred to a general hospital. There should be further investigation if there were no improvement. Febrile fits is common; it is usually treated with paracetamol and some common antibiotics. The first plaintiff was admitted with symptoms of febrile fits. The first defendant gave the correct preliminary treatment. If febrile fits, if even given the above treatment, is not contained within two to three days, there should be a further investigation. The first defendant did the right thing by referring the first plaintiff to the second defendant.

[13] Under cross-examination, DWI said that the first defendant Pontian did review the initial diagnosis, that meningitis should have been 'foreseen', that a lumbar puncture is the only procedure way to confirm meningitis, that any doctor at the first defendant hospital could perform a lumbar puncture, that he could not see any record of a lumbar puncture, that not all cases of febrile fits need a lumbar puncture, that a lumbar puncture should be performed if febrile fits is continuing, that all doctors are trained to perform a lumbar puncture, that there was no improvement in the condition of the first plaintiff between 21 March 1978 and 23 March 1978, that the first plaintiff had febrile fits on 21 March 1978. DW1 could not say if the second defendant gave the correct treatment. Under re-examination, DW1 said that from the referral letter he could see that there was a review of the case, that there was an initial diagnosis followed by a second set of treatment, and then followed by the transfer of the case to the second defendant. There was a review. To perform a lumbar puncture, a patient must be admitted. DW1 said that he had not seen the inpatient record of the first plaintiff, and so he could not say if a lumbar puncture was performed. The finding of the panel 'febrile fits in childhood' was based on the available records (D2 and D2A). DW1 could not say if recurring fits caused the retardation. The panel found that the central nervous system of the first plaintiff was normal. It meant that muscle development was normal, and also that meningitis could not be ruled out. To the court's question 'besides meningitis, what other medical condition could cause mental retardation or arrest mental development' that was not objected to by both counsel, DW1 answered 'drugs consumption, trauma, bad malaria, severe septic conditions, encephalitis, tumour, blockage of the brain canals and venereal diseases'.

[14] DW2 (Sahman bin Salame — a hospital attendant at the Pontian Hospital) testified that he was on duty at the Pontian Hospital on the night of 20 March 1978 until the morning of 21 March 1978. DW2 said that he

made those medical notes in D2B (those underlined). He recorded what was said by the second plaintiff. He was informed that the first plaintiff had two bouts of fits on the night in question. Febrile fits was his preliminary opinion. Under cross-examination, DW2 said that there was a doctor on call, but he could not remember whether he/she was summoned. DW2 agreed that the doctor on call should be summoned. DW2 said he could not identify the maker of those medical notes not made by him. There was a ward record of the first plaintiff. Under re-examination, DW2 said that a doctor would be called only if it were necessary.

[15] DW3 (Mohd Yusof bin Ibrahim — an Assistant Administrative Officer of the second defendant) testified that he could not trace the inpatient record of the first plaintiff, as the second defendant do not keep records after 10 years, and that all records would be destroyed after permission had been obtained from the National Archives. 'Saya berkeyakinan rekod Udhaya Kumar telah dilupuskan'. There is no record of what medical records had been destroyed.

[16] The last witness for the defence (DW4 — Dr Lim Nyok Ling) was a Consultant Paediatrician with a long and impressive resume of her expertise and experience (see D4) and attached to the Selayang Hospital, Selangor. DW4 testified as follows. She was a child specialist, and a neonatologist — a doctor specialising in the medical care of critically ill newborn babies. She was acquainted with febrile fits, and with infections affecting the central nervous system (CNS), in young children. Febrile fits is a common condition affecting young children from three months–five years old; it is fits due to a fever and not fits due to an infection of the CNS. Fits is a result of rapid and excessive electrical discharges from the brain. Fits is an involuntary action. Fits is manifested as involuntary bodily movements and or muscle tone. In febrile fits, there would be a history of preceding fever, maybe with cough and cold, and episodes of fits during rapid rise in temperature. What was recorded in D2 (those underlined) is a classic case of febrile fits. There was no vomiting. There is a low probability of vomiting in febrile fits. Without the symptom of vomiting, the usual diagnosis is febrile fits. With the symptom of vomiting, the doctor should consider other causes. The treatment in D2 is consistent with proper treatment for febrile fits. She served at the first defendant hospital between 1983 and 1984. The first defendant Hospital was competent to treat febrile fits. An initial diagnosis of febrile fits may be reviewed in the light of new symptoms or recurrence of old symptoms, or where circumstances warrant it.

[17] DW4 further explained that the referral letter (D2A) stated the following. The diagnosis was fever of unknown origin with fits. The patient was admitted with febrile fits. The patient was treated with antibiotics for two days. The patient did not respond. The treatment was changed to another antibiotic dispensed at 12noon. The patient did not respond. The temperature was still spiking. There were convulsions for about $1^1/_2$ minutes either on that day or that there was loss of consciousness. Valium was administered to stop the fits. The cause of the fever was not apparent. The test for malaria was negative. The patient was referred to the JB Hospital.

[18] Then having compared D2 with D2A, DW2 said that the treatment in D2 was reviewed to the treatment in D2A, and that the management in D2 was different from the management in D2A, in that syrup erythromycin, antibiotics, a penicillin injection and valium were stated in D2A but not in D2. Convulsions and spiking fever were also not recorded in D2. In prescribing erythromycin, the doctor had considered bacterial infection as the cause. And when erythromycin was not effective, the doctor prescribed a different antibiotic administered by injection. Febrile fits can be related to any infection that can cause fever, but it is not due to an infection of the CNS. The CNS includes the brain and the brain covering. Based on D2A, the first plaintiff had complex febrile fits or an infection of the CNS. In simple fits, there is no recurrence of fits during the same episode of fever but in the instant case, there was a history of fits on admission and also fits subsequent to the date of referral. There was a recurrence of fits. It could have been an infection of the CNS, because in the case of recurrence of fits in the presence of fever in young children, there is a high probability of infection of the CNS. Between 1983 and 1984, the Pontian Hospital was not equipped to manage complex fits or infection of the CNS. Complex febrile fits and infection of the CNS should be referred to a higher-level hospital. Where more than just simple febrile fits is suspected, a lumbar puncture would be performed to assist in the diagnosis. If the first plaintiff were tied to his bed, it could have been to prevent him from pulling and or removing the intravenous drip necessary in the treatment of complex febrile fits or infection of the CNS. An X-ray would not help in the diagnosis of meningitis or encephalitis. A patient is shaved to enable an intravenous infusion to be inserted to the scalp. Infection of the CNS is either infection of the brain matter, which is called encephalitis, or infection of the membrane covering the brain and spinal chord, which is called meningitis, or infection of both. Meningitis and encephalitis are caused by bacteria or virus, but rarely by fungus. In children, infection of the CNS by virus is more prevalent than by bacteria. Febrile fits is not an infection of the CNS. In febrile fits, a child has fits because of fever caused by infection outside the CNS. In febrile fits, there is no infection of the CNS. Then DW4 expressed her opinion that the first plaintiff had suffered a CNS infection, more likely viral encephalitis. Whether it is viral or bacterial encephalitis is material to the management of the infection. Based on the findings in D1, it was encephalitis. The first Plaintiff had encephalitis and not meningitis, because he has severe mental retardation and aggressive behaviour but yet at the same time he has a normal motor system. In meningitis and where there is severe mental retardation, there is likely to be a disability in the motor system — motor system means muscle power, tone, reflexes and function. It was encephalitis and not febrile fits; there must be recurrent febrile fits to cause the present retardation, it would not have ended with just the one episode of illness (see p 77). There was no recurrence of fits after the instant episode. In febrile fits and encephalitis, the initial manifestation is the same. Both would manifest fever and fits. In meningitis, there would

be the symptoms of vomiting, headache, neck stiffness, abnormal tone, motor system abnormality; those symptoms are absent in febrile fits. Infebrile fits, meningitis or encephalitis, the initial fever and fits would be common symptoms. But those symptoms would distinguish themselves. 'Therefore I say that the initial diagnosis by Pontian Hospital was correct. Even if Pontian's diagnosis were encephalitis, the treatment would still have been the same treatment, namely paracetamol for fever, monitoring the fever, and medicine for fever. Only difference would be that a district hospital would not further manage the patient but would send the patient to a General Hospital, because of the likely complication of the case. The initial diagnosis and management at Pontian were appropriate, and when fits recurred, the patient was referred promptly to JB, which was also appropriate. In my opinion, given the condition of the patient, febrile fits was unlikely to have caused the present retardation. But initial diagnosis of febrile fits was not inappropriate. In encephalitis cases, the initial diagnosis would be febrile fits, but with other symptoms, the diagnosis would change to encephalitis or meningitis. Pontian was not equipped to handle encephalitis. Pontian had no facilities to perform a lumbar puncture. Encephalitis is well known to lead to severe retardation despite correct treatment. That would be true also of meningitis. Retardation does not indicate a want in the treatment. Pontian had correctly diagnosed and managed the case, and then appropriately referred the case to a higher hospital, when the patient did not respond. In my opinion, the present condition of the first plaintiff was due to encephalitis.'

[19] Under cross-examination DW4 said that she based her opinion on D1, D2A and D2B. DW4 agreed that she would be able to give a clearer and better opinion if she had the case notes of the first plaintiff. DW4 said that based on D1, D2A and D2B, she was confident that it was encephalitis, but added, 'I cannot say how it was managed at Pontian or JB. Since it was just fever, the case need not be transferred to JB. But when fits recurred on the day of referral or day three of admission, the patient was referred. In case of meningitis or encephalitis, early treatment may or may not affect the outcome. But in cases of bacterial infection, prompt and adequate treatment with antibiotics is likely to help with a better outcome'. DW4 agreed that given the facts in D2A a lumbar puncture would be needed, but said that the first defendant had referred the first plaintiff to the second defendant. 'A lumbar puncture has been around since the 1960's. Every doctor knows how to perform a lumbar puncture. But having a laboratory to do the analysis is more important. There was no facility in Pontian to do an analysis of the spinal fluid. I know that in Pontian it was the standing order not to perform lumbar puncture but to refer to JB. I have checked that even today a lumbar puncture is not procedure at Pontian. It is very likely that a large part of the patient's retardation was caused by infection of the brain matter. It could be, but it is not likely that meningitis was the cause. Febrile fits is a medical condition and specific diagnosis. The diagnosis 'febrile fits' in D1 is not a statement of the symptoms. I disagree with the diagnosis of febrile fits. I say it would be viral encephalitis because more than 90% of the cases are due to viral

causes. I say that the present condition of the first plaintiff is due to past infection of the brain matter — encephalitis. I cannot say what was the treatment at JB. I cannot say whether the treatment was or was not adequate'. DW4 was not re-examined.

[20] When trial commenced, it was not an agreed fact that the first plaintiff became retarded at about the time of his admission to the first defendant hospital on 21 March 1978. It was only much later, indeed only at the stage of legal submissions that Ms Alice Loke Yee Ching for the defendants conceded that the first plaintiff became retarded at about the time of his admission to the Pontian Hospital on 21 March 1978. If that was an agreed fact much earlier, then it might not have been necessary at all for PW1, the psychiatrist, to be put to such length to explain why it was his opinion that the first plaintiff would have mentally retarded since infancy. But not every bit of PW1's testimony was rendered academic. Still relevant to the disputed issue is the following testimony of PW1. The cause for the mental state of the first plaintiff was probably due to an infection during infancy, of the brain matter or meninges. Fever is a symptom in either meningitis or encephalitis. The other symptoms of meningitis are stiffness of the neck, and weakness in either the upper or lower limbs. Alumbar puncture is standard procedure, since the 1960's, to establish the diagnosis of meningitis. A lumbar puncture is standard procedure if meningitis is suspected, but not if meningitis is not suspected. Any doctor should be able to perform a lumbar puncture. ' ... It is possible that the first plaintiff is mentally retarded because of some viral fever when he was young, but because of the history of treatment for fever and fits at the Pontian Hospital, I would say that the mental retardation was related to fever and fits'. Meningitis should not be ruled out in the instant case as fever and fits had continued for more than 2 hours. A lumbar puncture need not be performed immediately — 'It is done after observation'.

[21] In gist, it was the opinion of PW1 that the mental retardation of the first plaintiff was related to fever and fits during infancy, that that fever was due to meningitis or encephalitis, and that a lumbar puncture is standard procedure if meningitis is suspected.

[22] DW1 informed that meningitis is an infection of the meninges, that meningitis is caused by virus (the most common), bacteria, or fungus, and that the symptoms in meningitis also apply to encephalitis. But DWl was also tentative on the cause for the said mental retardation. DW1 said that the infection in the instant case could not be limited to just meningitis and or encephalitis, and that meningitis as the cause should not be excluded. DW1 would not say that recurring fits caused the retardation. With regard to the treatment recorded in D2B, DW1 said as follows. Erythromycin and C penicillin would be adequate treatment in the case of simple bacteria fever. The diagnosis of pyrexia of unknown origin and febrile fits was the correct diagnosis. Erythromycin and C penicillin was adequate treatment at the first defendant hospital, but that the first plaintiff should be referred to a general hospital for further investigation, when there was no improvement. DW1 further enlightened as follows. Febrile fits is high temperature in

children causing fits. Febrile fits if not treated could cause the child to suffer brain damage. Febrile fits is common but meningitis is the cause in only 10%–15% of the cases. Febrile fits is usually treated with paracetamol and some common antibiotics, but if it is not contained within two to three days, there should be further investigation. DW1 further opined as follows. The first plaintiff was admitted with symptoms of febrile fits, and the first defendant gave the correct preliminary treatment. The first defendant took the right action by referring the first plaintiff to the second defendant. The first defendant did review the initial diagnosis. Meningitis should have been taken into consideration. There was no record of a lumbar puncture in the instant case. Any doctor could perform a lumbar puncture, the only procedure to confirm meningitis. A lumbar puncture should be performed if febrile fits is continuing. There was no improvement in the condition of the first plaintiff between 21 March 1978 and 23 March 1978. DW1 could not comment on whether the second defendant had given the correct treatment, but said that there was a review of the initial diagnosis, in that there was an initial diagnosis followed by a second set of treatments and then followed by the transfer of the case to the second defendant. DW1 further related that the finding of the panel 'febrile fits in childhood' was based on D2 and D2A, that the CNS of the first plaintiff was normal.

[23] In short, it was the opinion of DW1 that the infection could have been meningitis or encephalitis or other causes, that the Pontian Hospital gave the correct preliminary treatment, that there was a review of the case, and that a lumbar puncture should be performed if febrile fits is continuing. It was the finding of fact of the panel that the CNS of the first plaintiff was normal.

[24] But DW4 was much more forthright, informative and lucid in her opinion. First she explained that febrile fits is a common condition affecting young children from three months to five years old, due to a fever but not to an infection of the CNS — 'febrile fits can be related to any infection that causes a fever, but it is not due an infection of the CNS' (see p 71 of the notes of proceedings). DW4 further informed that in febrile fits there would be a history of preceding fever, maybe with cough and cold, and episodes of fits during rapid rise in temperature, and that there is a low probability of vomiting. Without the symptom of vomiting, DW4 said that the usual diagnosis is febrile fits, but with the symptom of vomiting the doctor should consider other causes. DW4 explained that there was no symptom of vomiting in the instant case, and the treatment in D2 was consistent with proper treatment for febrile fits. DW4 testified that the Pontian Hospital, where she had a tour of duty between 1983 and 1984, was competent to treat febrile fits.

[25] Next, DW4 spelt out the management in the outpatient card and the management in the referral letter. Then DW4 compared the management in those two medical records, and said that the management in D2 was different from the management in D2A. DW4 pointed out that the symptoms of convulsions and spiking fever, and the administration of syrup erythromycin, antibiotics, penicillin injection and valium were stated

in the referral letter but not in the outpatient card. DW4 said that the prescription of erythromycin meant that the doctor did consider bacterial infection as the cause, but when erythromycin was not effective, the doctor prescribed a different antibiotic administered by injection. DW4 stressed that febrile fits is not due to an infection of the CNS, and she explained that the CNS includes the brain and the brain covering. DW4 said that based on D2A, the first plaintiff had complex febrile fits or an infection of the CNS. DW4 explained as follows. In simple fits, there is no recurrence of fits during the same episode of fever. But in the instant case, there was a history of fits on admission and also fits subsequent to the date of referral. There was a recurrence of fits. It could have been an infection of the CNS, because in the case of recurrence of fits in the presence of fever in young children, there is a high probability of infection of the CNS.

[26] Then DW4 explained why it was an infection of the CNS, more likely to have been viral encephalitis, in words as follows. Infection of the CNS is either infection of the brain matter, which is called encephalitis, or infection of the membrane covering the brain and spinal cord, which is called meningitis, or infection of both. Meningitis and encephalitis are caused by bacteria or virus, but are only rarely caused by fungus. In children, infection of the CNS by virus is more prevalent than by bacteria. Febrile fits is not an infection of the CNS. In febrile fits, a child has fits because of fever caused by infection outside the CNS. In febrile fits, there is no infection of the CNS. Whether it is viral or bacterial encephalitis is material to the management of the infection. Based on the findings in D1, it was encephalitis. The first plaintiff had encephalitis and not meningitis, because he has severe mental retardation and aggressive behaviour but yet at the same time he has a normal motor system. In meningitis and where there is severe mental retardation, there is likely to be a disability in the motor system — motor system means muscle power, tone, reflexes and function. It was encephalitis and not febrile fits; there must be recurrent febrile fits to cause the present retardation, it would not have ended with just the one episode of illness (see p 77). There was no recurrence of fits after the instant episode. In febrile fits and encephalitis, the initial manifestation is the same. Both would manifest fever and fits. In meningitis, there would be the symptoms of vomiting, headache, neck stiffness, abnormal tone, motor system abnormality; those symptoms are absent in febrile fits. In febrile fits, meningitis or encephalitis, the initial fever and fits would be common symptoms. But those symptoms would distinguish themselves. 'Therefore I say that the initial diagnosis by Pontian Hospital was correct. Even if Pontian's diagnosis was encephalitis, the treatment would still have been the same treatment, namely paracetamol for fever, monitoring the fever, and medicine for fever. Only difference would be that a district hospital would not further manage the patient but would send the patient to a General Hospital, because of the likely complication of the case. The initial diagnosis and management at Pontian was appropriate, and when fits recurred, the patient was referred promptly to JB, which was also appropriate'.

[27] In my opinion, given the condition of the patient, febrile fits was unlikely to have caused the present retardation. But initial diagnosis of febrile fits was not inappropriate. In encephalitis cases, the initial diagnosis would be febrile fits, but with other symptoms, the diagnosis would change to encephalitis or meningitis. Pontian was not equipped to handle encephalitis. Pontian had no facilities to perform a lumbar puncture. Encephalitis is well known to lead to severe retardation despite correct treatment. That would be true also of meningitis. Retardation does not indicate a want in the treatment. Pontian had correctly diagnosed and managed the case, and then appropriately referred the case to a higher hospital, when the patient did not respond. In my opinion, the present condition of the first plaintiff was due to encephalitis'.

[28] Clearly, DW4 was explicit in her opinion. First she said that based on D2A the first plaintiff had complex febrile fits — or an infection of the CNS. She discounted simple fits, because in simple fits there is no recurrence of fits during the same episode of fever. Then DW4 narrowed the cause to encephalitis, DW4 explained that in meningitis and where there is severe mental retardation, there is likely to be a disability in the motor system. But the motor system of the first plaintiff is normal, and meningitis could be discounted. DW4 then said that febrile fits could not have caused the retardation. DW4 explained that there was only one episode of illness in the instant case, but there must be recurrent febrile fits to cause the present retardation. And it was DW4 who displayed the most profound knowledge on the subject of febrile fits, meningitis and encephalitis. DW4 was methodical and analytical. And she furnished medical fact and medical knowledge for each step of her analysis. It was not an *ipse dlxit* opinion that encephalitis was the cause. DW4 clearly formulated her opinion on the basis of solid medical fact and solid medical knowledge. Her opinionclearly satisfied the threshold of logic. But there is further compelling reason to accept the opinion of DW4. Only DW4 had testified that in meningitis there would be the symptoms of vomiting, headache, neck stiffness, abnormal tone, motor system abnormality. DW4 testified that those symptoms are absent in febrile fits. And true enough, according to *The British Medical Association Complete Family Health Encyclopaedia,* 'the main symptoms of meningitis are fever, severe headache, nausea and vomiting, dislike of light and a stiff neck'. But there was no symptom of vomiting in the instant case. Hence, one main symptom of meningitis was absent in the instant case. It only follows that meningitis could not be suspected, and a lumbar puncture that is only performed to confirm a diagnosis of meningitis could not fall into the equation. Thus, the want of a lumbar puncture, if that were the case, was not any want in management on the part of the defendants.

[29] The fact of the matter is that a lumbar puncture would not have made an iota of difference in the instant case. A lumbar puncture is only a medical procedure to establish the diagnosis of meningitis. A lumbar puncture is not any treatment *per se.* The initial diagnosis of the first defendant was tentatively febrile fits — 'Febrile fits adalah pendapat awal saya. Sebab itu

saya tulis 'Q' untuk query di sebelah Febrile fits' (see p 62 of the notes of proceedings). The finding of the panel was 'febrile fits in childhood'. Both DW1 and DW4 said that the initial diagnosis and or treatment were correct. And given the fact that even PW1 for the plaintiffs had nothing adverse to say about the initial diagnosis and treatment, and therefore there was no divergence of views, there is really no evidential basis for to say that the initial diagnosis and treatment were wrong. But that initial diagnosis and or treatment were evidently reviewed. Both DW1 and DW4 said there was a review. Indeed, there must have been a review of the initial diagnosis, as the initial treatment of syrup paracetamol and syrup phenesdyl (see D2) was changed to syrup erythromycin for two days and then to injection crystalline penicillin, and valium on 23 March 1978 (see D2A). PW1 alleged that the same medicine was administered, and that it was the same treatment until 23 March 1978. But that allegation could not be further from the truth.

[30] On the matter of the revised treatment at the first defendant hospital, DW1 said that erythromycin and crystalline penicillin were adequate treatment at the first defendant Hospital, but that there should be a further investigation if there were no improvement within two to three days. DW4 said, 'the initial diagnosis and management at Pontian were appropriate, and when fits recurred, the patient was referred promptly to JB, which was also appropriate'. The effect of the testimony of DW1 and DW4 was that the management and treatment at the first defendant hospital were appropriate and adequate, that the first defendant had reviewed the case, and that the first defendant had promptly transferred the first plaintiff to the second defendant hospital. The plaintiffs contend to the contrary. But the plaintiffs had not adduced any evidence to the contrary. The only opinion before the court was that the management and treatment at the first defendant hospital were appropriate and adequate, and that there was no delay in the management and treatment of the first plaintiff. That singular opinion before the court was unchallenged at that. Again there was no divergence of views. It must add up that there was no evidence that the revised treatment at the first defendant hospital was inappropriate or inadequate and or that there was any delay in the management and or treatment at the first defendant hospital. Without the evidential basis, it would be wrong to hold to the contrary.

[31] As for the management and treatment at the second defendant hospital, it is an unknown. The defendants could produce none of the medical records of the first plaintiff at the second defendant hospital. Mr Harjit Singh for the plaintiffs urged the court to invoke s 114(g) of the Evidence Act 1950. But an 'adverse inference under [s 114(g)] can only be drawn if there is withholding or suppression of evidence and not merely on account of failure to obtain evidence' *Munusamy v Public Prosecutor* [1987] 1 MLJ 492 per Mohamed Azmi SCJ). DW3 testified that he could not trace the inpatient record of the first plaintiff, as the second defendant would destroy all records after 10 years — 'Saya berkeyakinan rekod Udhaya Kumartelah dilupuskan'. DW1 confirmed that that it is the practice to

destroy all records after seven years, if it is not needed for medico-legal reasons. But this action was filed some 20 years after the event, after the inpatient record of the first plaintiff would have been destroyed in the course of practice said by both DW1 and DW3. There was no medico-legal reason at the material time not to destroy the inpatient record of the first plaintiff hospital. There was no withholding or suppression of evidence in the instant case. It would not be unfair to say that the non-availability of the inpatient records of the first plaintiff was brought about solely by the plaintiffs. The plaintiffs could not expect the defendants to keep their records forever. And the plaintiffs should not lay blame at the defendants' door for their own inertia.

[32] It should go without saying that medical records make most significant evidence in a medical negligence action. Immediate steps should be taken to secure records, if action is contemplated. The reason is simple enough. A claimant would need those records as essential proof to establish negligence. The position in law is that 'In order to establish liability, and to obtain an award of compensation against a doctor or a hospital, it must be proved that on a balance of probabilities there has been negligence in law. In the field of professional negligence, there is no liability without proof of fault' (*F v Chan Tanny* [2003] 4 SLR 231 per Lai Kew Chai J). 'In a case like the present, the burden of proving causation remains throughout on the plaintiff. But there may be particular cases where an inference of causation may be readily drawn against a defendant warranting an explanation from him. In those circumstances, it may be entirely proper for the court to look to the defendant for a reasonable explanation negativing causation. This is not a rule of law but a mere rule of common sense. *McGhee v National Coal Board* [1972] 3 All ER 1008 illustrates the point (*Dr Soo Fook Mun v Foo Fio Na & Anor and another appeal* [2001] 2 MLJ 193, at p 202). 'To succeed in an action based on negligence, whether against a doctor or against anyone else, it is necessary to establish a breach of that duty to take care which the law requires, and the degree of want of care which constitutes negligence must vary with the circumstances' (see *Dr Chin Yoon Hiap v Ng Eu Khoon & Ors* [1998] 1 MLJ 57, at p 76, following *Hunter v Hanley* [1955] SLT 213).

[33] As to the standard of proof of medical negligence, the a test was formulated by McNair J in *Bolam v Friern Hospital Management Committee* [1957] 2 All ER 118, at p 121 where he said:

> Before I turn to that, I must explain what in law we mean by 'negligence'. In the ordinary case which does not involve any special skill, negligence in law means this:
>
> 'Some failure to do some act which a reasonable man in the circumstances would do, or doing some act which a reasonable man in the circumstances would not do; and if that failure or doing of that act results in injury, then there is a cause of action. How do you test whether this act or failure is negligent? In an ordinary case, it is generally said that you judge that by the action of the man in the street. He is the ordinary man. In one case, it has been said that you judge it by the conduct of the man on the top of a Clapham omnibus. He is the

ordinary man. But where you get a situation which involves the use of some special skill or competence, then the test whether there has been negligence or not is not the test of the man on the top of a Clapham omnibus, because he has not got this special skill. The test is the standard of the ordinary skilled man exercising and professing to have that special skill. A man need not possess the highest expert skill at the risk of being found negligent. It is well established law that it is sufficient if he exercises the ordinary skill of an ordinary competent man exercising that particular art. I do not think that I quarrel much with any of the submissions in law which have been put before you by counsel. Counsel for the plaintiff put it in this way, that in the case of a medical man, negligence means failure to act in accordance with the standards of reasonably competent medical men at the time. That is a perfectly accurate statement, as long as it is remembered that there may be one or more perfectly proper standards; and if a medical man conforms with one of those proper standards then he is not negligent.'

[34] And the above test was applied by the Privy Council in *Chin Keow v Government of Malaysia & Anor* [1967] 2 MLJ 45, by the Federal Court in *Kow Nan Seng v Naaamah & Ors* [1982] 1 MLJ 128, by the Court of Appeal in *Dr Chin Yoon Hiap v Ng Eu Khoon* and *Dr Soo Fook Mun v Foo Fio Na*, by the High Court in numerous decisions, and indeed by many jurisdictions. But of late there have been pleas to discard the *Bolam* test. In *Dr Chin Yoon Hiap v Ng Eu Khoon* it was urged upon the court to follow some Australian cases (*F v R* [1983] 33 SASR 189, *Ropers v Whitaker* [1992] 109 ALR 625 and *Naxakis v Western General Hospital* [1999] HCA 22) that departed from the *Bolam* test. Declining so to do, the Court of Appeal per Gopal Sri Ram JCA said:

I have come to the conclusion that we ought not alter the approach. There are two broad reasons for this. First, as a matter of precedent, I do not think that it is open to us, as an intermediate court of appeal, to alter the law. That is a function reserved for the apex court. Secondly, as a matter of practical justice, the *Bolam* test places a fairly high threshold for a plaintiff to cross in an action for medical negligence. It is right that this be so. If the law played too interventionist a role in the field of medical negligence, it will lead to the practice of defensive medicine. The cost of medical care for the man on the street would become prohibitive without being necessarily beneficial. For the time being the *Bolam* test maintains a fair balance between law and medicine. There may perhaps come a time when we will be compelled to lower the intervention threshold if there is a continuing slide in medical standards. But that day has not yet come.

[35] In *R (on the application of N) v Doctor M and others* [2002] EWCA Civ 1789, [2003] 1 FLR 667, [2003] 1 FCR 124, 72 BMLR 81, it was proposed that in a case where there is a responsible body of opinion that a patient is not suffering from a treatable condition, then it cannot be convincingly shown that the treatment proposed is medically necessary. However the Court of Appeal held that that submission is in effect a reverse *Bolam* test.

We reject this submission. This is, in effect, a reverse '*Bolam*' test: see *Bolam v Friern Hospital Management Committee* [1957] 2 All ER 118, [1957] 1 WLR 582, which was approved by the House of Lords in *Bolitho v City and Hackney Health Authority* [1997] 4 All ER 771, [1998] AC 232. It is too well known to require

stating that a professional person is not guilty of negligence if he has acted in accordance with a practice accepted as proper by a responsible body of persons who practice the same art, merely because there is a body of opinion who would take a contrary view.

[36] The facts in *Rogers v Whitaker* were as follows:

[37] The appellant, an ophthalmic surgeon, conducted surgery on the respondent's right eye with the required skill and care, but was held liable by the trial court on account of his failure to warn the respondent that as a result of surgery on her right eye she might develop a condition known as sympathetic ophthalmia in her left eye. Sympathetic ophthalmia did occur and the respondent ultimately lost all sight in her left eye. The appellant argued that the issue of whether the failure to advise and warn constituted a breach of the appellant's duty of care should be resolved by application of the *Bolam* principle, derived from the direction given by McNair J to the jury in *Bolam v Friern Hospital Management Committee* [1957] 1 WLR 582 to the effect that a doctor is not negligent if he acts in accordance with a practice accepted at the time as proper by a responsible body of medical opinion even though other doctors adopt a different practice. Before the trial court there was evidence from a body of reputable medical practitioners that, in the circumstances of the present case, they would not have warned the respondent of the danger of sympathetic ophthalmia; there was also evidence from similarly reputable medical practitioners that they would have given such a warning. The respondent had questioned the appellant as to the possible complications, including the danger of unintended or accidental interference with her 'good' left eye. The Court of Appeal dismissed all grounds of the appellant's appeal from the judgment of A$808,564.38 on both liability and damages. Dismissing the further appeal, the High Court of Australia held that the question is not whether the conduct accords with the practice of the medical profession or some part of it, but whether it conforms to the standard of reasonable care demanded by the law, and that that is a question for the court, and the duty of deciding it cannot be delegated to any profession or group in the community; *F v R, Battersby v Tottman* (1985) 37 SASR 524, *Gover v South Australia* (1985) 39 SASR 543, *Ellis v Wallsend District Hospital* (1988 unreported), and *E v Australian Red Cross Society* (1991) 99 ALR 601 were approved, while *Bolam v Friern* and *Sidaway v Board of Governors of Bethlem Royal Hospital* [1985] AC 871 were disapproved.

[38] In their joint judgment, Mason CJ, Brennan, Dawson, Toohey and McHugh JJ said:

One consequence of the application of the *Bolam* principle to cases involving the provision of advice or information is that, even if a patient asks a direct question about the possible risks or complications, the making of that inquiry would logically be of little or no significance; medical opinion determines whether the risk should or should not be disclosed and the express desire of a particular patient for information or advice does not alter that opinion or the legal significance of that opinion. The fact that the various majority opinions in *Sidaway,* for example, suggest that, over and above the opinion of a respectable

body of medical practitioners, the questions of a patient should truthfully be answered (subject to the therapeutic privilege) indicates a shortcoming in the *Bolam* approach. The existence of the shortcoming suggests that an acceptable approach in point of principle should recognise and attach significance to the relevance of a patient's questions. Even if a court were satisfied that a reasonable person in the patient's position would be unlikely to attach significance to a particular risk, the fact that the patient asked questions revealing concern about the risk would make the doctor aware that *this patient* did in fact attach significance to the risk. Subject to the therapeutic privilege, the question would therefore require a truthful answer.

In Australia, it has been accepted that the standard of care to be observed by a person with some special skill or competence is that of the ordinary skilled person exercising and professing to have that special skill. But, that standard is not determined solely or even primarily by reference to the practice followed or supported by a responsible body of opinion in the relevant profession or trade (see, eg *Florida Hotels Pty Ltd v Mayo* (1965) 113 CLR 588 at pp 593 and 601). Even in the sphere of diagnosis and treatment, the heartland of the skilled medical practitioner, the *Bolam* principle has not always been applied (See *Albrighton v Royal Prince Alfred Hospital* [1980] 2 IMSWLR 542, at pp 562–563 (case of medical treatment). See also *E v Australian Red Cross* (1991) 27 FCR 310, at p 360. Further, and more importantly, particularly in the field of non-disclosure of risk and the provision of advice and information, the *Bolam* principle has been discarded and, instead, the courts have adopted (*Albrighton v Royal Prince Alfred Hospital* [1980] 2 NSWLR at pp 562–563; F v R (1983) 33 SASR 189, at pp 96, 200, 202, 205; *Battersby v Tottman* (1985) 37 SASR at pp 527, 534, 539, 540; *E v Australian Red Cross* (1991) 27 FCR at pp 358–360) the principle that, while evidence of acceptable medical practice is a useful guide for the courts, it is for the courts to adjudicate on what is the appropriate standard of care after giving weight to 'the paramount consideration that a person is entitled to make his own decisions about his life (*F v R* (1983) 33 SASR at p 193).

[39] As said, the Court of Appeal in *Dr Soo Fook Mun v Foo Fio Na* declined to follow *Rogers v Whitaker.* But *Rogers v Whitaker* was applied in *Kamalam a/p Raman & Ors v Eastern Plantation Agency (Johore) Sdn Bhd Ulu Tiram Estate, Ulu Tiram, Johore & Anor* [1996] 4 MLJ 674, where Richard Talalla J distinguished both *Bolam* and *Elizabeth Choo v Government of Malaysia & Anor* [1970] 2 MLJ 171, and said (at p 691):

> Accordingly I do not find myself by reference to *Kow's* case being fettered by the *Bolam* principle but on the contrary bound by the ruling of Salleh Abas FJ, set out above which ruling corresponds with the ruling by the then Lord President in *Swamy*'s case and I propose to adopt by way of elaboration of those rulings the abovementioned dicta extracted from the decision in the *Rogers*' case. Ishould emphasize that while due regard will be had to the evidence of medical experts, Ido not accept myself as being restricted by the establishment in evidence of a practice accepted as proper by a responsible body of medical men skilled in that particular art to finding a doctor is not guilty of negligence if he has acted in accordance with that practice. In short I am not bound by the *Bolam* principle. Rather do I see the judicial function in this case as one to be exercised as in any other case of negligence, unshackled, on the ordinary principles of the law of negligence and the overall evidence.

[40] James Foong J, in *Hong Chuan Lau v Dr Eddie Soo Fook Mun* [1998] 7 MLJ 481, also applied *Rogers v Whitaker.* His Lordship said (at p 497):

> For sometime, the *Bolam* test ie the test expounded by McNair J in *Bolam v Friern Hospital Committee* was accepted to be applicable to all provisions of a doctor's duty to his patient. But by a series of cases in the United States of America, Canada and Australia, the *Bolam* test is rejected as regards to the doctor's duty to disclose information and advice to the patient. In order to explain the reasons for this departure from the *Bolam* test and the arguments against it, and the new test proposed as its substitution, I shall follow the approach adopted by the Justices of the High Court of Australia in their judgment of *Christopher Rogers v Maree Lynette Whitaker.*

[41] Then further down, at p 499, his Lordship said:

> ... after considering the reasonings and arguments so succinctly put forth by the persuasive foreign authorities, I am of the view that the principles in *Christopher Rogers* should be adopted ... Thus in considering whether a doctor has breached his duty in respect of the provision on information and advice, the court rather than a body of medical opinion shall be the judge of this issue.

[42] Now whether *Bolam* remains the test may soon be addressed. The Federal Court in *Foo Fio Na v Dr Soo Fook Mun & Ors* [2002] 2 MLJ 129 has granted leave to appeal against the decision of the Court of Appeal, and the main question for which leave was sought was whether the *Bolam* test as enunciated in *Bolam v Friern,* in the area of medical negligence should apply in relation to all aspects of medical negligence, specifically to the duty and standard of care of a medical practitioner in providing advice to a patient on the inherent or material risks of the proposed treatment. The outcome is yet uncertain. *Bolam* is still the *locus classicus.* In any event, the outcome, whatever it will be, is not material to the instant issue.

[43] The issue is negligence in the diagnosis and treatment, and management. The first plaintiff was discharged with severe mental retardation. But that is not to say that *res ipsa loquitur* automatically applies. Each case must be decided in accordance with its particular facts. In the instant case both the first and second defendants gave an explanation of the diagnosis and treatment, and management. Both DW1 and DW4 were definite that the initial diagnosis and treatment were correct. Both DW1 and DW4 were definite that the initial diagnosis and treatment were reviewed. Both DW1 and DW4 said that there was a second set of treatments at the first defendant hospital. DW1 affirmed that the second set of treatments were adequate. Both DW1 and DW4 said that the first defendant took the appropriate action by referring the first plaintiff to the second defendant hospital. DW4 said that the first plaintiff was referred 'promptly'. DW4 also said that encephalitis is known to cause severe retardation despite correct treatment. But to the above, there was no divergent opinion or rejoinder from PW1. The plaintiffs adduced evidence relating to lumbar punctures. But more crucially, the plaintiffs failed to offer proof that the diagnosis and treatment were not in accordance with the standards of reasonably competent medical men at the time. In the

result, the plaintiffs had not proved negligence against the first defendant. The fact that there was no lumbar puncture was not proof of negligence. DW4 made it so evident that meningitis could not have been the probable cause. Even PW1 for the plaintiffs would not pin it down to meningitis. PW1 said it was meningitis or encephalitis. In contrast, DW4 clearly demonstrated that the probable cause was encephalitis. On the balance of probabilities, the cause was encephalitis. A lumbar puncture or absence thereof would not have been of consequence. In so far as the case against the second defendant is concerned, the plaintiffs had not even offered any evidence on the diagnosis and treatment at the second defendant hospital, let alone evidence on negligence. Simply put, there was no case for the second defendant to answer. Granted, the plaintiffs could not secure the inpatient records. But they put themselves on the spot. It would be an absolute travesty if the defendants were made to answer for the plaintiffs' failure to discharge the burden of proof. The onus was on the plaintiffs to show, on a balance of probabilities, that there was a causative link between the resultant damage and the negligent act of the defendants (*Wiltsher v Essex Area Health Authority* [1988] 1 All ER 871). But the plaintiffs failed to show that the resultant mental retardation was caused by any negligent act of the defendants. And even if there were a prima facie case under the doctrine *of res ipsa loquitur,* the defendants had rebutted negligence. Fairly said, the evidence of the case negated all negligence on the part of the defendants.

[44] The award on the amount of damages, if the finding on negligence were otherwise, would be as follows. Given the severe mental retardation, there would be a total loss of amenities, a fact conceded by the defendants. Mr Harjit referred to *Inderjeet Singh a/l Piara Singh v Mazlan bin Jasman & Ors* [1995] 2 MLJ 646, where RM200,000 was awarded for brain injury and partial quadriplegia, and suggested an award between RM180,000 and RM210,000. Miss Loke referred to *Ahmad Daman Huh bin Hussein v Koo Chin Yau* [1990] 3 MLJ 53, where RM90,000 was awarded for loss of mental faculties, *Yang Salbiah & Anor v Jamil bin Harun* [1981] 1 MLJ 292, where RM70,000 was awarded for pain and suffering and loss amenities (the plaintiff became vegetative), and *Jamil bin Harun v Yang Kamsiah & Anor* [1984] 1 MLJ 217, where RM70,000 was awarded for pain, suffering and loss of amenities (the plaintiff was turned into a sub-normal child with permanent mental and physical disabilities), and suggested an award of RM100,000. With those authorities as a guide, the award is RM200,000 for loss of amenities. Given the same severe mental retardation, there would be total disability for life. The second plaintiff testified that the first plaintiff requires constant care. On that, none should disagree with the second plaintiff. In his submission, Mr Harjit asked for RM500 per month for pre-trial nursing care from 1978 to 1997, and for RM700 per month for post-trial nursing care for 16 years. Miss Loke submitted that no evidence was led on that claim. That may well be true. But it must stand to reason that the first plaintiff would need constant care. And that would involve expense. The sum sought is moreover not unreasonable. The award is a sum of RM600 per month towards pre-trial and post trial nursing care for

35 years. All awards shall carry pre-trial and post-trial interests at the rate of 8%pa. The defendants shall reimburse the plaintiffs for the costs (RM120) of the reports. The latter is provisional. The definitive order is that the plaintiffs' claim is dismissed with costs.

Plaintiffs' claim dismissed.

Reported by AG Kalidas